

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00094
138

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town W. Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Murree St.

How long in hospital or institution?

3. (a) FULL NAME

Margaret V. Bailey

3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

William R. Bailey

6.(c) If alive, give age years

September 9th 1906

7. Birth date of deceased (mo., day, yr.)

41 4 16

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Annapolis, A.A.C. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

Daniel Mc Corcle

13. Birthplace

Annapolis, Md.

14. Maiden name

Laura Collins

15. Birthplace

Annapolis, Md.

16. Informant

Mrs. Wm R. BaileyAddress W. Annapolis, Md.

17. Burial

Date thereof 1/28/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Cedar Bluff Cemetery

Location

Annapolis, Md.

18. Funeral director

John M. Taylor Son

Address

Annapolis, Md.

19. Jan. 28 1948

Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County A.A.C.City or town W. Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. Murree Street

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 25 1948 at 9:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1947 to Jan 25 1948and that I last saw her alive on Dec 8 1947

Immediate cause of death

Ch. Pulmonary Tuberculosis 6 mos +

Due to

Due to

Other conditions

Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. J. Klavans, Md.

M. D. or other

Address Annapolis, Md. Date signed 1/26/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00695
24

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Anne Arundel

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

3. (a) FULL NAME

Grover Cleveland Bell

3. (b) Social Security Number

4. Sex

Male | 5. Color or race White | 6. (a) Single, married, widowed, or divorced Married

Trace Elliott Bell

6. (b) Name of husband or wife.....

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

Sept 3^d 1892

8. AGE:

Years 55 Months 4 Days 17 If less than one day hrs. min.

9. Birthplace.....

(Town, county, and state) Warsaw Ala.

10. Usual occupation.

James News paper

11. Industry or business

John W. Bell

12. Name.....

Warsaw Ala.

13. Birthplace.....

Margaret E. Barnes

14. Maiden name.....

Hinton Tex

15. Birthplace.....

Mrs Carrie B. Albright

16. Informant.....

38 Maryland Ave Baltimore Md.

Address.....

17. Removal.....

Date thereof.....

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Jan. 22 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Tenn County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 20 1948 at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 16 1948 to Jan 20 1948 and that I last saw him alive on Jan 20 1948

Immediate cause of death.....

Myocardial chv wth Myocardial insufficing whom

Due to.....

Due to.....

Gastric hew peccal years

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

George C. Basile M. D. or other

Address..... Date signed 1-21-48

RECEIVED

JAN 23 1948

FBI - BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

518

000966

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel
 City or town Lindenhurst
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs
 Hospital, institution, or street address where death occurred:
Patapsco

How long in hospital or institution? none

3. (a) FULL NAME

John Blackwell

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Married

8.(b) Name of husband or wife Mystie Elma Brooks Blackwell
 7. Birth date of deceased (mo., day, yr.) July 19 1917 6.(c) If alive, give age 95 years

8. AGE: Years 70 Months 6 Days 9 If less than one day
 hrs. 0 min. 0

9. Birthplace Florence, S.C.
(Town, county, and state)

10. Usual occupation Tenach Farmer

11. Industry or business Private

12. Name Unknown MOTHER FATHER

13. Birthplace Unknown

14. Maiden name Mary Thompson

15. Birthplace 5-S

16. Informant Mystie A. Blackwell
 Address Lindenhurst Heights, Patapsco and

17. Burial Date thereof Jan 25 48
(Burial, cremation, or removal. Which?)

Cemetery or crematory Patapsco Location Patapsco, MD

Location Elmwood Wilson

18. Funeral director Elvyn D. Wilson

Address 1000 Brantley Ave

19. Date rec'd by registrar Jan 24 1948 A.W. Hedrick

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Anne Arundel County Lindenhurst
 City or town Lindenhurst
(If outside city or town limits, write RURAL and give nearest town)
 Street No. Patapsco
(If rural, give LOCATION)

2.(a) If veteran, name war none

3. (b) Social Security Number none

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1948 at 9:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1947 to Jan 22 1948

and that I last saw him alive on Jan 21 1948

Immediate cause of death

Myocardial Dysfunction 6 mo

Due to Cancer of prostate 6 mo

Due to General arterio sclerosis 2 yrs

Other conditions Hypertension 2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State) —

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE B.B. Brumbaugh M. D. or other —

Address Elkhorn Ridge Date signed 4/23/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

S3a

00098

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Anne Arundel
 City or town..... Annapolis, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? one Hour

3. (a) FULL NAME

ANNA ELIZABETH BRASHEARS

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Charles Lee Brashears

6. (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.)

June 3, 1914

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Prince George County, Maryland
 (Town, county, and state)

10. Usual occupation

Sect.

11. Industry or business

Bank

MOTHER FATHER

12. Name

Samuel Coale

13. Birthplace

Maryland

14. Maiden name

Helen Griffith

15. Birthplace

Maryland

16. Informant

Mr. Charles Lee Brashears

Address

Parole, Anne Arundel, Maryland

17. Burial

Date thereof 1-14-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

St. Anne's Cemetery

Location

Annapolis, Maryland

18. Funeral director

Ben L. Hopping and Son

Address

Annapolis, Maryland

Jan. 13 1948
 (Date rec'd by registrar)George L. Brashears
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Parole nr Annapolis
 (If outside city or town limits, write RURAL and give nearest town)Street No. South River Rd.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 10 1948 at 1145 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 - 9 pm 1948 to Jan 10 - 1145 p.m. 1948 and that I last saw her alive on Jan 10 a.m. 1948.

Immediate cause of death

Cerebral Hemorrhage
 Pt. Semiplegia

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George L. Brashears

M. D. or other

Address Annapolis, Maryland Date signed Jan 11 1948

Dr. Basit



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00097

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

County

City or town

Anne Arundel
Emergency Hospital

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 hours 10 minutes

Hospital, institution, or street address where death occurred

Emergency Hospital

How long in hospital or institution? 19 hours 10 minutes

3. (a) FULL NAME

Carl Brodin

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Joy Brodin

6. (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.)

Sept 8, 1903

8. AGE:

Years
44Months
4 mo.Days
1

If less than one day

hrs.

min.

9. Birthplace

Columbus, North Dakota

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Gustav Brodin

MOTHER FATHER

Svendson

Pauline Brodin

Hopper Lee

Prost Lee

Shady Side

Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan 20 1948
(month) (day) (year)

Cemetery or crematory Quaker Cem.

Location Galesville Md.

D. G. Shady Side & Son.

Address Galesville Md.

Jan 20 1948

(Date rec'd by registrar)

John M. Clegg, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

Maryland

County

Cecil Co.

City or town

Emergency Hospital

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

✓

3. (b) Social Security Number

✓

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 18 1948 7¹⁰ AM21. I CERTIFY that death occurred on the date above stated: Postmortem examination
and body found alive on Jan 18 1948

Immediate cause of death

Cardio-respiratory failure

Due to

2nd + 3rd degree
burns of Head, back
and all extremities

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident Date of

Where did injury occur

Edgewater City of town

Baltimore County

Maryland State

1-17-48

None

Death medical

Examiner

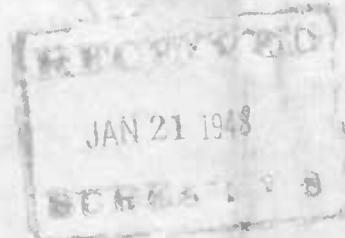
1-18-48

Date signed

Address

Worship Wm. M. Clegg, M.D.

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No.

006921

1. PLACE OF DEATH:

County.....

Anne Arundel

City or town.....

Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Bessie W. Brown

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Wm H. Brown

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

June 10th 1876

8. AGE:

Years
71Months
6Days
28

If less than one day

hrs. min.

9. Birthplace

Annapolis, A.O.C., Md.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

Benjamin Holiday

MOTHER

Annapolis, Md.

14. Maiden name

Julia Hesterly

15. Birthplace

Maryland

16. Informant

William H. Brown

Address

Eastport, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof
(month) (day) (year)
11/11/48

Cemetery or crematory

St. Anne's Cemetery

Location

Annapolis, Md.

18. Funeral director

John M. Taylor, San

Address

Annapolis, Md.

19. Jan 11 1948

(Date rec'd by registrar)

W. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

A.A. Co.

City or town.....

Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No.

932 Frances Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 8th

1948 at 10:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 29 1947 to Jan 8 1948

and that I last saw her alive on Jan 8 1948

Immediate cause of death

Cerebral Hemorrhage 1 hr

Due to

Arterial hypertension several years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Oliver Purvis
Annapolis, Md.

M. D. or other

Address

Jan 9 1948 Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00100
108

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel
 County
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 Life

How long in above place of death? _____
 Hospital, institution, or street address where death occurred:
 Parole Md. near Annapolis

How long in hospital or institution? _____

3. (a) FULL NAME

Daniel Edward Brown

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Married

6. (b) Name of husband or wife
 Mildred Brown7. Birth date of deceased (mo. day, yr.) April 2, 1911
 6. (c) If alive, give age years

8. AGE: Years	Months	Days	It less than one day
36	9	15	hrs. min.

9. Birthplace
 (Town, county, and state)
 Parole, Md. near Annapolis

10. Usual occupation Utility Helper

11. Industry or business None

12. Name Daniel Brown

13. Birthplace Hopes Chapel

14. Maiden name Lottie Brown

15. Birthplace Annapolis, Maryland

16. Informant Mildred Brown

Address Box 10 Route 1 Parole, Md.

17. Burial Date thereof 1-21-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brewer Hill

Location West Street Extended

18. Funeral director Mrs. Charles E. Hicks

Address 43-45 Northwest Street

19. Jan 21, 48
 (Date rec'd by registrar)2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State	Maryland	County	Anne Arundel
City or town	Parole Md. near Annapolis	(If outside city or town limits, write RURAL and give nearest town)	
Street No.	Parole, Md. near Annapolis	(If rural, give LOCATION)	

2.(a) If veteran, name war. _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17, 1948 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10, 1948, to Jan 17, 1948

and that I last saw him alive on Jan 19, 1948

Immediate cause of death Sobar Pneumonia

DURATION

7 day.

Due to
 (Cause of death)Due to
 (Cause of death)Other conditions
 (Include pregnancy within 3 months of death)Major findings of operations
 (Operations)

Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Hudson H. Johnson M.D.*
 M. D. or other

Address 40 Northwest Street Date signed 1/21/48

RECORDED

JAN 22 1948

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00101

170c

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 hours 35 minutes
Hospital, institution, or street address where death occurred: Annapolis Emergency Hospital
How long in hospital or institution? 6 hours, 35 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Davidsonville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D.
(If rural, give LOCATION)

3. (a) FULL NAME

Male | 5. Color or race: negro | 6. (a) Single, married, widowed, or divorced: single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo. day, yr.): Feb 25 1936. 6. (c) If alive, give age: years

8. AGE: Years: 11 Months: 11 Days: 15 If less than one day: hrs. min.

9. Birthplace: Davidsonville A.A. Co. Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

MOTHER FATHER: 12. Name: George Brown
13. Birthplace: A.A. Co. Md.

MOTHER: 14. Maiden name: Rachael Green
15. Birthplace: A.A. Co. Md.

16. Informant: Rachael Green
Address: Davidsonville Md.

17. Burial: Date thereof: Jan 12 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Davidsonville
Location: Davidsonville Md.

18. Funeral director: A. Barducci & Sons
Address: Salisbury Md.

19. Date rec'd by registrar: Jan 12 1948
(Date rec'd by registrar)

3. (b) Social Security Number: none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 10 1948 at 3²⁰ M

21. I CERTIFY that death occurred on the date above stated; that Postmortem Examination was made and that death occurred alive on 19

Immediate cause of death: Severe Concussion

Due to: Blow to Brain with
Sub-dural hemorrhage

Post to: Fracture of right femur
upper third

Other conditions: (Include pregnancy within 8 months of death)

Major findings of operations: Date of op.

Autopsy results: Date of

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 1-9-48

Where did injury occur: Davidsonville A.A. Maryland
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route 214

Means of Injury: automobile (Automobile) Injured at work? No

Signature: John M. Coffey M.D. Deputy Medical Examiner
Address: Annapolis, Md. M. D. Examiner

Date signed: 1-10-48



I PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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bc
Reg. Dist. No. 00102

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Anne Arundel

County

Crownsville

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs. 4 mos.

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 7 yrs. 4 mos.

3. (a) FULL NAME

MARY A. BROWN

4. Sex
female5. Color or race
negro6. (a) Single, married, widowed, or divorced
married

6. (b) Name of husband or wife

Willard Brown

6. (c) If alive, give age unknown years

7. Birth date of deceased (mo., day, yr.)

1918

8. AGE: Years

30

Months

Days

If less than one day

hrs.

min.

9. Birthplace: Atlantic City, New Jersey

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

12. Name: Robert McQuinn

New Jersey

13. Birthplace

Veronica Jennings

14. Maiden name

—

15. Birthplace

16. Informant

Hospital Records

Address

Crownsville, Maryland

17. Burial

Date thereof: Jun. 23, 1948

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

Mt. Zion

Location

Baltimore, Maryland

18. Funeral director

Tom George & Son

Address

163, Druid Hill Ave.

19. (Date rec'd by registrar)

19.

A. W. Harbeck

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2501 Francis St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

January 19

48 at 9:10 a.m.

2d. DATE OF DEATH: October 19, 41, to Jan. 19, 48

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

October 19, 41, to Jan. 19, 48

and that I last saw her alive on Jan. 19, 48

Immediate cause of death

Tuberculosis of the Spine (cold abscess)
known to us since

DURATION

8/28/47

Due to

Due to

Other conditions: Dementia Praecox

known to us since

9/18/40

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Jacob M. D.

M. D. or other

Address: Crownsville, Md. Date signed: 1/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00103

(111c)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

Anne Arundel
County.....
City or town.....

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life

Hospital, institution, or street address where death occurred:

88 College Creek Terrace

How long in hospital or institution?

3. (a) FULL NAME

William Norman Brown

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.)

September 4, 1912

6. (c) If alive, give age..... years

8. AGE:

Years Months Days If less than one day

35

4

13

hrs.

min.

B. Birthplace.....

West River Anne Arundel Co. Md.

(Town, county, and state)

10. Usual occupation.....

None

11. Industry or business

None

MOTHER

Matthews Brown

FATHER

West River, Anne Arundel Co. Md.

14. Maiden name.....

Mamie Randall

15. Birthplace

West River Anne Arundel Co. Md.

16. Informant.....

Mamie Randall

Address

West River Anne Arundel Co. Md.

17. Burial

Date thereof January 22, 1948
(Burial, cremation, or removal. Which?)

(month)

(day)

(year)

Cemetery or crematory.....

Smithville nr. Annapolis Md.

18. Funeral director.....

Mrs. Charles E. Hicks

Address

43-45 Northwest Street

Jan. 22, 1948
(Date rec'd by registrar)

Registers

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County..... Anne Arundel

City or town.....

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

88 College Creek Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 17

19

at 12:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 1948 to Jan 19 1948

and that I last saw him alive on Jan 18 1948

1948

Immediate cause of death

The postoperative hemorrhage,
resulting from debilitated condition
from the polio paralysis

Due to

Patient had Polio at age 18 mos. From this
time was confined & bedridden. (2-16-48) Q.S.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

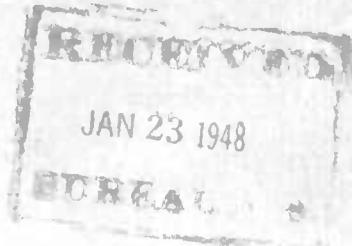
23. SIGNATURE

G.T. Allen M.D.

M. D. or other

Date signed. 1-16-48

Address



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00104

CERTIFICATE OF DEATH

Reg. Dist. No. 25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
 County..... A. County
 City or town..... Brooklyn Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 3 months
 Hospital, institution, or street address where death occurred:
 4400 Gov. Ritchie Highway
 How long in hospital or institution?.....

3. (a) FULL NAME
 Elizabeth E. Bunn

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife..... David R. Bunn

7. Birth date of deceased (mo., day, yr.) January 8, 1869

8. AGE:	Years	Months	Days	If less than one day
	79		3	hrs. min.

9. Birthplace..... Decatur, Ind.
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

FATHER	12. Name..... N. Gilson
	13. Birthplace..... Ind.

MOTHER	14. Maiden name..... M. Ayres
	15. Birthplace..... Ind.

16. Informant..... Mr. Russell G. Bunn

Address 4400 Gov. Ritchie Highway

17. Burial Date thereof Jan. 15, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Glendale Cemetery

Location..... Akron, Ohio

18. Funeral director..... Milton Shilling - Schilling

Address 3914 Hanover st. Baltimore, Md.

19. Date rec'd by registrar..... Ida M. Whelchel
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Ohio	County.....
City or town..... Akron	(If outside city or town limits, write RURAL and give nearest town)
Street No..... ?	(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number
 NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 11, 1948, at 10.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18 1947, to January 11, 1948

and that I last saw her alive on January 10, 1948

Immediate cause of death..... Heart failure

Due to..... Generalized arterial-sclerosis
 and Parkinson's disease

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... George A. Kipp

M. D. or other

Address 3030 Edmondson Ave. Date signed 1/12/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00105

108

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH:

County

St. Margaret's

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

B.(a) Single, married, widowed, or divorced

Female Colored married

Allen Champ

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day. yr.)

1896

8. AGE: Years Months Days If less than one day
52 0 0 0 hrs. min.

9. Birthplace Eastport Md

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

Robert Dogood

12. Name of mother

Harriett Wilson

13. Birthplace Md

14. Maiden name Allen Champ

15. Birthplace Md

16. Informant st. Margaret At. Co.

17. Burial Date thereof 2/4/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Broadneck

Location St. Margaret -

18. Funeral director B. Johnson

Address Campaparia

Feb. 4 1948 - O'Donnell

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

St. Margaret's

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 1948

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 27 1948 to Jan. 31 1948

and that I last saw her alive on Jan. 31 1948

Immediate cause of death

Lobar Pneumonia

Due to

Due to

Other conditions

Acute Myocarditis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

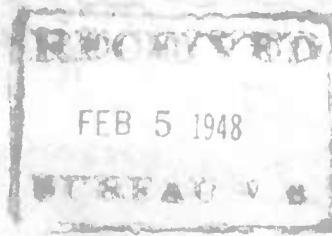
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. B. Richardson M. D. or other

Address 108 - 6th St. Annapolis, Md. Date signed Feb. 3/1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d
00106
21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

13 Monument St.

How long in hospital or Institution?

3. (a) FULL NAME Joseph Coates

4. Sex male | 5. Color or race Negt | 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Josephine Coates

7. Birth date of deceased (mo., day, yr.) June 15, 1880

8. AGE: Years 66 Months 7 Days 5 If less than one day hrs. min.

9. Birthplace Davidsonville, Md.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Joseph Coates

MOTHER FATHER 12. Name Joseph Coates

13. Birthplace Davidsonville, Md.

14. Maiden name Josephine Coates

15. Birthplace Davidsonville

16. Informant Mrs. Josephine Coates

Address 13 Monument St.

17. Burial Date thereof 1-25-48

(Burial, cremation, or removal, Which?) Crematory

Cemetery or crematory Crematory

Location Smithfield

18. Funeral director William Reese Jr.

Address 108 Washington St., Annapolis, Md.

19. Jan 24, 48

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Annapolis, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 13 Monument

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21, 1948 at 10:30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 21, 1948, to Jan 21, 1948

and that I last saw him alive on 19.

Immediate cause of death Cardiac Failure

DURATION 1 day

Due to Hypertensive Cardio-Vascular Disease

Duo to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph T. Johnson, M.D.

M. D. or other no longer practice

Address 108 Washington St., Annapolis, Md.

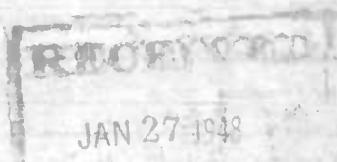
Date signed Jan 24, 1948

Registrar

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RECEIVED IN LIBRARY



JAN 27 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00107

CERTIFICATE OF DEATH

28

Reg. Dist. No.

1. PLACE OF DEATH:

Anne Arundel
County

City or town Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 14 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 4 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

Wards over no. 1 ✓

2.(a) If veteran, name war.

3.(a) FULL NAME

ISAAC COOK

4. Sex Male	5. Color or race Negro	6.(a) Single, married, widowed, or divorced Married
-------------	------------------------	---

6.(b) Name of husband or wife Unknown to us

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) 49 - 1898

8. AGE: Years 49	Months ?	Days ?	If less than one day hrs. min.
------------------	----------	--------	--

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business

12. Name Joseph Cook

13. Birthplace Maryland

14. Maiden name Mary?

15. Birthplace Maryland

16. Informant Hospital Records

Address Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 14-48
(month) (day) (year)

Cemetery or crematory Melville Green Md

Location Key Salisbury Md

18. Funeral director George P. Steward

Address Salisbury Md

19. Jan 10 1948 E. Joyce Local
(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12th 1948 at 1:00P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29th 1847 to January 12th 1948 and that I last saw h. i.m. alive on January 12th 1948.

Immediate cause of death General Paresis Known to us since 8-29-47

Due to.

Due to.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. ----- Date of -----

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

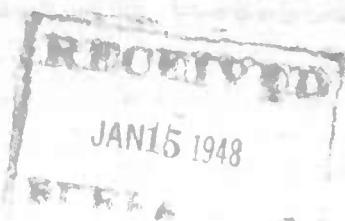
Means of injury

Injured at work?

23. SIGNATURE Dr. John Morganstein M.D.

M. D. or other

Address Crownsville, Maryland Date signed 1/12/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00108
93d

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH:

Anne Arundel

Crownsville, Maryland

City or town. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years, 4 months, 12 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 33 years, 4 months, 12 days

3. (a) FULL NAME

MOLLIE COTMOND (COTTON)

4. Sex

Female

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

1872

8. AGE:

Years
75Months
?Days
?If less than one day
..... hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

16. Informant

Hospital Records

Address

Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?)

Date thereof

1/22/48
(month) (day) (year)

Cemetery or crematory

Crownsville Cemetery

Location

Crownsville

18. Funeral director

Crownsville Md

Address

Crownsville Md

19. Date rec'd by registrar

Jan 24, 1948

(Date rec'd by registrar)

E. J. for a Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Crownsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. No home

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15th 1948 at 12:00P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1941 to January 15th 1948 and that I last saw her alive on January 15th 1948

Immediate cause of death

Myodegeneratio cordis (Arteriosclerosis)

known to us since

Due to

DURATION

6 months

Due to

Other conditions Psychosis With Mental

Deficiency (Hemiplegia) known to us
(Include pregnancy within 3 months of death) since 9/3/1914

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

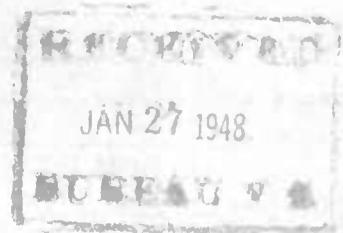
Injured at work

23. SIGNATURE

Dr. Jacob Margolin, M.D.

M. D. or other

Address Crownsville, Maryland Date signed 1/15/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Unreadable age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00158
83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Anna Goodrich Leavitt Cresap

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Lt. Col. Dr. James C. Cresap

6. (c) If alive, give age years

December 7th 1860

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 87 Months 1 Days 12 If less than one day

hrs.

min.

9. Birthplace

Oxford Ohio
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

John McDowell Leavitt12. Name John McDowell Leavitt13. Birthplace Steubenville, Ohio14. Maiden name Bethia Brooks15. Birthplace Cincinnati, Ohio16. Informant Zoeyne CresapAddress Annapolis, Md.17. Burial Date thereof 1/22/48
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Naval Academy CemeteryLocation Annapolis, Md.18. Funeral director John W. Taylor SonAddress Annapolis, Md.19. Jan. 22 1948
(Date rec'd by registrar)-0-
-0-
-0-

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty A.A. Co.City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 Oklahoma Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Jan 19 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 7 1947 to Jan 19 1948and that I last saw her alive on Jan 19 1948

Immediate cause of death

Central Hemorrhage with left main stem plug.

Due to

Arterio SclerosisArtoral Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

3. SIGNATURE

J. Oliver Purvis M. D. or otherAddress Annapolis, Md. Date signed Jan 20/48

1-2-2

RECORDED

JAN 23 1948

BCRA

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00109
83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County..... Anne Arundel

City or town..... Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

3. (a) FULL NAME

Sarah Estelle

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... A. A. Co.

City or town..... Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 145

Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

B.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Richard E. Crosby

7. Birth date of deceased (mo., day, yr.)

Feb. 23d 1880

6.(c) If alive, give age..... years

8. AGE:

Years
67Months
11Days
21

If less than one day

hrs.
.....min.
.....

9. Birthplace

A. A. Co., Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Anne Stallings

12. Name

A. A. Co., Md.

13. Birthplace

Susan Austin

14. Maiden name

A. A. Co., Md.

15. Birthplace

Mrs. Joseph Macaluso

16. Informant

Annapolis, Md.

Address

Burial

Date thereof

1/19/48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

John M. Taylor

Funeral director

Address

Jan. 19, 1948

(Date rec'd by registrar)

J. C. Board

Signature

Date signed

1-18-48

Address

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 16 1948 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 1948 to Jan 16 1948

and that I last saw her alive on Jan 16 1948

Immediate cause of death

Cerebral Hemorrhage

or embolism

DURATION Jan 10 1948

Due to

Hypertension

Due to

arteritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

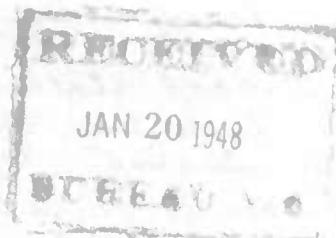
Injured at work?

23. SIGNATURE

George C. Board M. D. or other

Address

Annapolis, Md. Date signed 1-18-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00110

21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Anne Arundel

City or town

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

McDonough Hall U.S. Naval Academy

How long in hospital or institution?

3. (a) FULL NAME

Clavis Deladrier

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Marguerite Deladrier

6. (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

Jan. 7, 1876

8. AGE:

Years	Months	Days	If less than one day
62	0	12	hrs. min.

9. Birthplace

Belgium
(Town, county, and state)

10. Usual occupation

Fencing instructor U.S. N.A.

11. Industry or business

Zale Deladrier

12. Name

Belgium

13. Birthplace

Catherine Willock

14. Maiden name

Belgium

15. Birthplace

Mrs. Clavis Deladrier

16. Informant

Burial

Date thereof Jan. 27, 1948
(month) (day) (year)

Cemetery or crematory

Naval Academy

Location

Annapolis, Md.

18. Funeral director

John M. Taylor Son

Address

Annapolis, Md.

19. Jan. 26, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County Anne Arundel

City or town

(If outside city or town limits, write RURAL and give nearest town)

Annapolis

Street No.

Lynxton Hgts.

(If rural, give LOCATION)

(a) If veteran, name war

</



JAN 27 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00157

22

Reg. Dist. No.

1. PLACE OF DEATH:

Anne Arundel County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George E. Diegel

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m white Singh

6. (b) Name of husband or wife.....

John H. Diegel

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

January 20, 1850

8. AGE:

Years
97Months
11Days
17

If less than one day

hrs. min.

9. Birthplace.....

GERMANY

(Town, county, and state)

10. Usual occupation.....

Retired FARMER

11. Industry or business

12. Name..... John H. Diegel

13. Birthplace..... Germany

14. Maiden name..... Elizabeth Brown

15. Birthplace..... Germany

16. Informant.....

Mrs. Oden Pumphrey

Address

Ferndale, A.A. Co. Maryland

17. Burial

Date thereof..... 1-6-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... St. Anne's Cemetery

Location..... Annapolis, Maryland

18. Funeral director..... Ben L. Hopping and Son

Address..... 170-172 West St. Annapolis, Md.

19. Jan 5 1948
(Date rec'd by registrar)Dava Hasleby
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Anne Arundel County.....

City or town.....

Rural (If outside city or town limits, write RURAL and give nearest town)

Street No.....

SEVERN

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 3 - 1948 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 15 1947 to Jan 3 1948 and that I last saw him alive on Jan 3 1948

Immediate cause of death.....

Cerebral Thrombosis 2 days

Due to.....

Seizure

Due to.....

Cardio Vasc Disease

DURATION

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

M. D. or other

Address.....

FEB 10 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00111

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Gen. color single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Jan. 13 1948

6.(c) If alive, give age years

8. AGE:

Years Months Days If less than one day

10 hrs. min.

9. Birthplace

(Town, county, and state)

Garleigh Heights Md.

10. Usual occupation.....

11. Industry or business

Isaac Dixon

12. Name

Catoctinville Md.

13. Birthplace

Elizabeth Stewart

14. Maiden name

Garleigh Heights

15. Birthplace

Elizabeth Stewart Dixon

16. Informant

Burial

17. Address

First Bapt Church Cem.

Cemetery or crematory

Garleigh Heights

Location

J.B. Johnson

18. Funeral director

Donafoia

Address

L.A. Breit

19. Jan. 26 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 26 1948 at 11:30 AM

Post mortem Examination

January 23 1948

Immediate cause of death

Bronch pneumonia

Duration 6 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

27. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Dr. M. Caffey M.D. Surgeon

Address Baltimore Md. Date signed 1-23-48

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00112

CERTIFICATE OF DEATH

Reg. Dist. No.

23

1. PLACE OF DEATH:

County..... Anne Arundel

City or town.....

Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Ellsworth Donaldson

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

None

7. Birth date of

deceased (mo., day, yr.) September 30, 1943.

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

4

4

1

hrs.

min.

9. Birthplace.....

University Hospital, Baltimore, Md.
(Town, county, and state)

Due to.....

10. Usual occupation.....

None

11. Industry or business

12. Name..... Alfred Donaldson

13. Birthplace.....

Severn, Md. R.F.D.

14. Maiden name..... Lillian Marie Mooney

15. Birthplace..... Baltimore, Md.

16. Informant..... Howard Donaldson

Address

Severn, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb. 2, 1948
(month) (day) (year)

Cemetery or crematory..... Glen Haven Momo. Park

Location..... Glen Burnie, Md.

18. Funeral director..... Thomas W. Singleton

Address

Glen Burnie, Md.

19. (Date rec'd by registrar)

19-48

Z. J. O'Leary

Registered

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Severn, R.F.D.
(If outside city or town limits, write RURAL and give nearest town)Street No..... Donaldson Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 31-48 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 30-48 1948and that I last saw him/her alive on *Jan 30-48* 1948

Immediate cause of death

Pneumonia

DURATION

2 day

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

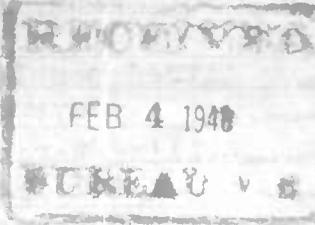
Injured at work?

23. SIGNATURE

George Ellsworth Donaldson

M. J. or other

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00113

46d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Glen Burnie, Md.

(If outside city or town limits, write RURAL and give nearest town)

28 years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

ELIZABETH W. ENDERLE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

B. (b) Name of husband or wife Eugene C. Enderle

Deceased

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1880

8. AGE: Years Months Days If less than one day
67 8 18 hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own Home

12. Name Henry Wolfram

13. Birthplace Lothra, Germany

14. Maiden name Amelia Taubert

15. Birthplace Leipzig, Germany

16. Informant Mrs. Ethel E. Bowen

Address 310 Crain Hwy. S.W. Glen Burnie,

17. Burial Date thereof Jan. 26, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodlawn

Location Baltimore, Md.

18. Funeral director Thomas W. Singleton

Address Glen Burnie, Md.

19. (Date rec'd by registrar) Jan 23, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No. 310 Crain Highway S.W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22nd 1948 at 10 ⁴⁵ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 21st 1948 to Jan. 22 1948

and that I last saw her alive on Jan. 26th 1948

Immediate cause of death Respiratory failure?

Paroxysm of Coughing 1 mos.

& multiple metastases

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations

Carcinoma of Rectum

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

Md.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

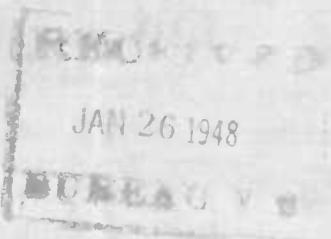
23. SIGNATURE

M. D. or other

Address 201 Bld. Annapolis Blk. Date signed Jan. 22 1948

Signature G. J. O. Alba

Registrar



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00114
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County. a. a.City or town. Brooklyn - 25

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? xx 4 -

Hospital, institution, or street address where death occurred:

715 Hammonds Lane

How long in hospital or institution?

3. (a) FULL NAME

Mary Engelberger4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Joseph Engelberger7. Birth date of deceased (mo., day, yr.) Sept. 9, 18848. (c) If alive, give age 72 years8. AGE: Years 63 Months 5 Days 5 If less than one day
..... hrs. min.8. Birthplace Hungary (Town, county, and state)10. Usual occupation House wife11. Industry or business Own Home12. Name UNKNOWN13. Birthplace Austria Hungary14. Maiden name UNKNOWN15. Birthplace Austria Hungary16. Informant Mr. Joseph EngelbergerAddress 715 Hammonds Lane - Brooklyn, Md. P.F.D.17. Burial, cremation, or removal, Which? Burial Date thereof Jan 28, 1948
(mmntb) (day) (year)Cemetery or crematory Holy CrossLocation Brooklyn - P.F.D. A.A. Co. Md.18. Funeral director Thomas W. SingletonAddress Glen Burnie, Md.19. Jan 26 1948 2 o'clock
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County a. a.City or town Baltimore 25

(If outside city or town limits, write RURAL and give nearest town)

Street No. 715 Hammonds Lane

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1948 At 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 25 1947 to Jan 24 1948and that I last saw her alive on Jan 12 1948

Immediate cause of death

Cardio-Tacular Disease

DURATION

2 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE Chas. L. Sall J. 2nd M. D. or otherAddress Linthicum Md. Date signed 1-24-48

8
C3
1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

468
00115

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County

City or town

Jessup, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Elmora L. M. Evans

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female W.

Widowed

6. (b) Name of husband or wife

Elsworth H. Evans

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

April 30, 1882.

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Huf.

11. Industry or business

Tobacco Growers

MOTHER FATHER

12. Name

Baltimore, Md.

13. Birthplace

Mary C. Greenwood

14. Maiden name

Virginia

15. Birthplace

Mrs. Charles Schneider

16. Informant

Lakesville, Md.

Address

Burial

Date thereof 1/31/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Meadow Ridge Mem. Park

Location

Dorsey, Md.

Funeral director

W. Cooke

Address

1217 St. Paul St., Baltimore, Md.

Date rec'd by registrar

January 30, 1948

A. W. Hough

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Jessup, Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

January 27, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 1947 to Jan 27, 1948

and that I last saw her alive on Jan 27, 1948

Immediate cause of death

Gastric Carcinoma

DURATION

6 mos.

Due to

✓

Due to

✓

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Gastric Carcinoma

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Shigley, M.D.

M.D. or other

Date signed

Address

Savage, Md.

1/28/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Cop for Hoff J

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00116

94a

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred:

104 West Street, Annapolis, Md.

How long in hospital or institution? -----

3. (a) FULL NAME

Albert William FISCHL

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Edith LaVerne Fischl - wife

6.(c) If alive, give age 30 years

7. Birth date of deceased (mo. day, yr.)

June 5, 1910

8. AGE:

Years
38

Months 7

Days 4

If less than one day

hrs.

min.

9. Birthplace

Allentown, Pennsylvania

(Town, county, and state)

10. Usual occupation

U.S. Navy

11. Industry or business

Not available

MOTHER FATHER

Name
Not available

13. Birthplace

Not available

14. Maiden name

Not available

15. Birthplace

16. Informant

U.S. NAVY records

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 1-14-48

(month) (day) (year)

Cemetery or crematory

Location Whitter, Calif

18. Funeral director

Ben L. Hopping and Son

Address 170-172 West St. Annapolis, Md.

19. Date rec'd by registrar

Jan 13 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 164 West Street

(If rural, give LOCATION)

2.(a) If veteran, name war World War II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 9

1948

at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 9

1948

to January 9 1948

and that I last saw him alive on January 9

1948

Immediate cause of death Thrombosis, coronary artery

Due to Coronary arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op.

Autopsy results Above plus pulmonary edema

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Address

*John M. Claffy M.D. Medical Examiner
Annapolis, Md. M.D. or other
Date signed 1-12-48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00157

Reg. Dist. No. 28

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County OxonCity or town Brownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years 10 months 8 days

Hospital, institution, or street address where death occurred:

Brownsville State HospitalHow long in hospital or institution? 8 years 10 months 8 days

3. (a) FULL NAME

Melvin Fisher

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Colored Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

8. AGE: approx 63 Years

Months

Days

If less than one day

approx unknown

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

William Fisher

12. Name

Marcella Dyles

13. Birthplace

Ind.

14. Maiden name

Marcella Dyles

15. Birthplace

Ind.

16. Informant

Hospital records

Address

Brownsville Ind

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan 14, 48

(month) (day) (year)

Cemetery or crematory

Oakland Spring Ind

Location

Roy W Barber

18. Funeral director

Roy W Barber

Address

Saylorsville Maryland19. 1/11/48

(Date rec'd by registrar)

19. E. F. Joyce

Signature of Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty HowardCity or town Jackson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10th 1948 at 3 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1941 to Jan 10th 1948 and that I last saw him alive on January 10th 1948

Immediate cause of death

Ischaemic myocarditis

Due to

Due to

Other conditions manic-depressive psychosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Jacob Margaster M.D.

M. D. or other

Address Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

00118

1. PLACE OF DEATH:

County A. A.

City or town Clearview Village

(If outside city or town limits, write RURAL and give nearest town)

2 yrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

FRANCES KATHARINE FORREST

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

fem.

white

married

6.(b) Name of husband or wife Charles W. Forrest

63

years

6.(c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

Feb. 6, 1894

8. AGE:

Years

Months

Days

If less than one day

53

II

I4

hrs.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER William Baek

13. Birthplace Baltimore, Md.

MOTHER MOTHER Louise Gross

14. Maiden name Germany

16. Informant Charles W. Forrest

Address P. O. Pasadena, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof T-24-48

(month) (day) (year)

Cemetery or crematory Western Cemetery

Location

18. Funeral director W. J. Tickner & Sons

Address North & Penna aves., Baltimore

19. Date rec'd by registrar

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County A. A.

City or town Clearview Village

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1948 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

I-20 1948 to I-20 1948

end that I last saw her alive on I-20 1948

Immediate cause of death

Cerebral hemorrhage

DURATION

2 hrs.

Due to Arteriosclerosis and hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

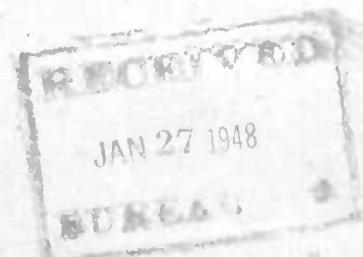
Injured at work

23. SIGNATURE

Leo A. Bleit M.D.

M. D. or other

Pasadena Md. 1-20-48 Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

179X

0011922
Reg. Dist. No.

1. PLACE OF DEATH:

County..... A.A.
 City or town..... Jessups, Md. (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 4 mo.
 Hospital, institution, or street address where death occurred:..... 4 month
 How long in hospital or institution?..... 16 hours

3. (a) FULL NAME

Issac Gainor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col'd	Married

6.(b) Name of husband or wife..... Helen
 7. Birth date of deceased (mo., day, yr.)..... Jan. 7, 1915
 8. AGE: Years Months Days If less than one day

33	-----	13	-----	hrs. ----- min.
----	-------	----	-------	-----------------

9. Birthplace..... Ironsides, Charles Co.
 (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... - - -

12. Name..... Issac Gainor

13. Birthplace..... Maryland

14. Maiden name..... Bertie

15. Birthplace..... Maryland

16. Informant..... Md. House Correction,

Address..... Jessups, Maryland

17. Removal Date thereof..... Jan 27 - 48
 (Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory..... Payne Cemetery

Location..... Washington D.C.

18. Funeral director..... Montgomery Bros.

Address..... 913 Fla Ave N.W.

19. Date rec'd by registrar..... Jan 24 1948
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... A.A.
 City or town..... Jessups (If outside city or town limits, write RURAL and give nearest town)
 Street No. - - - - - (If rural, give LOCATION)
 2.(a) If veteran, name war..... No

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 20, 1948 at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death..... Poisoning from drinking radiator anti-freeze solution.

Due to..... Exact type of solution pending chemical analysis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of 1-19-48

Where did injury occur?..... Solomon's Island Camp, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Same as above

Means of injury Rad. Anti-freeze at work? Yes

23. SIGNATURE..... John M. Claffy, M.D. or other

Address..... Deputy Med. Exam. Date signed 1-20-48.

Annapolis, Md.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00120

Reg. Dist. No.

21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Anne Arundel Co.,

City or town..... Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 58 years

Hospital, Institution, or street address where death occurred:

31 Larkins St.

How long in hospital or institution?..... *****

3. (a) FULL NAME

Louisa Giles

4. Sex

Female

5. Color or race

Col.

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

February 29, 1889

8. AGE:

Years
58

Months

Days

If less than one day

hrs. min.

B. Birthplace..... Davidsonville A. A. Co. Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business.....

None

MOTHER

FATHER

12. Name..... Henry Carroll

13. Birthplace..... Davidsonville

14. Maiden name..... Unknown

15. Birthplace..... Unknown

16. Informant..... Mrs Annie Willard

Address

31 Larkins St. Annapolis Md.

17. Burial.....

Date thereof..... January 4, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Brewer Hill Cemetery

Location.....

West St. extd. Annapolis Md.

18. Funeral director.....

Mrs Charles E. Hicks

Address

45 Northwest St. Annapolis Md.

19. Date rec'd by registrar.....

Jan 3 1948

(Date rec'd by registrar)

W. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 31 Larkins St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Jan 1

19 48 at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-12 1946 to 1-1 1947

and that I last saw her alive on 1-2-21 1947

19 47

Immediate cause of death.....

arteriosclerotic heart disease

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

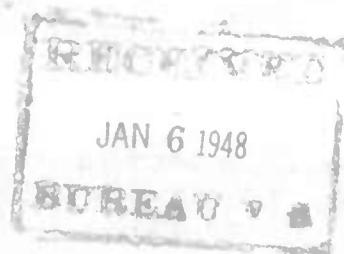
G. T. Allen

M. D. or other

Address.....

17 January

7-2-47 Date signed





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

82

CERTIFICATE OF DEATH

001212 2
Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel

City or town Laurel (rural)

(If outside city or town limits, write RURAL and give nearest town)

7 yrs.

How long in above place of death?

Hospital, Institution, or street address where death occurred:

District Training School

7 years

How long in hospital or institution?

3. (a) FULL NAME

Cecilia Goode

4. Sex F | 5. Color or race W | 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife none

7. Birth date of deceased (mo., day, yr.) October 9, 1900

8. AGE: Years Months Days If less than one day
47 3 hrs. min.9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

12. Name Webster Goode

13. Birthplace Maryland

14. Maiden name Emma (Goode)

15. Birthplace Maryland

16. Informant History at District Training School

17. Laurel, Maryland

Address

18. Burial Cemetery or crematory Cedar Hill
(Burial, cremation, or removal. Which?) Date thereof Jan 13-1948
(month) (day) (year)

Location Sutherland Rd.

19. Funeral director W.W. Chambers Co.

Address 1400 Chapin St. N.W.

Date rec'd by registrar Jan 14 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Laurel (rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10, 1948, at 4:32 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 15, 1940, to January 10, 1948,
and that I last saw her alive on January 10, 1948.

Immediate cause of death

Pneumonia (Bilateral Bronchopneumonia) 2 days

Due to

Due to

Other conditions Mental Deficiency-Embecile life
Amyotrophic lateral sclerosis ? life
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Richard O'Struff M.D.
M. D. or other
Address Laurel Md. Date signed 1/10/48

SEARCHED

JAN 23 1948

BUREAU OF INVESTIGATION

JAN 23 1948

BUREAU OF INVESTIGATION

1
T
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

81a

CERTIFICATE OF DEATH

W 00122
Reg. Dist. No. 21

1. PLACE OF DEATH Anne Arundel

County

Crownsville

City or town

(If outside city or town limits, write RURAL and give nearest town)

22 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution?

22 days

3. (a) FULL NAME

MINNIE GWYNN

4. Sex

female

5. Color or race

negro

6.(a) Single, married, widowed, or divorced

divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

August 19, 1914

8. AGE: Years

33

Months

5

Days

3

If less than one day

hrs.

min.

9. Birthplace

North Carolina

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

12. Name Richard Graham

13. Birthplace N. C.

14. Maiden name Minnie Spencer

15. Birthplace Virginia

16. Informant Hospital records

Address Crownsville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month day year)

Cemetery or crematory

Location Winston-Salem, N.C.

18. Funeral director

Address 918-1111 Hill Ave.

19. (Date rec'd by registrar)

18 48

W.D. & S. K.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Baltimore

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 619 Greenwillow St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1948 at 10:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 1948 to Jan. 28 1948

and that I last saw her alive on Jan. 28 1948

Immediate cause of death

Pachymeningitis - Hemorrhagica interna

DURATION

2 days

Due to

Due to

Other conditions Alcoholic Hallucinosis Known to us
Mental Deficiency since 1/6/48
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Jacob Marguerite M.D.

M. D. or other

Address Crownsville, Maryland Date signed 1/28/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00123

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County *Anne Arundel*
City or town *Annapolis*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *7 years*

Hospital, institution, or street address where death occurred:

17 Franklin St.

How long in hospital or institution?

3. (a) FULL NAME

Edward Hall, Jr.

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Wife Margaret Shatto Hall

7. Birth date of deceased (mo., day, yr.)

Dec. 31, 1880

6. (c) If alive, give age

63

years

8. AGE:

Years
*67*Months
*0*Days
*4*If less than one day
hrs. min.

9. Birthplace

Millsboro, A.C.C. Md.
(Town, county, and state)

10. Usual occupation

Surveyor

11. Industry or business

MOTHER FATHER

12. Name

Edward Hall

13. Birthplace

Millsboro, Md.

14. Maiden name

Eva Spence Wallis

15. Birthplace

Louisiana

16. Informant

Elizabeth Hall

Address

17 Franklin St.

17. Burial

(Burial, cremation, or removal. Where?)

Date thereof *January 6, 1948*
(month) (day) (year)

Cemetery or crematory

St Stephen's Church

Location

Chesterfield, A.C.C. Md.

18. Funeral director

Jesse M. Tamm, Son

Address

Chesterfield, D.D.

19. Date rec'd by registrar

Jan. 5, 1948

- 0,000.00

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Anne Arundel*City or town *Annapolis*
(If outside city or town limits, write RURAL and give nearest town)Street No. *17 Franklin St.*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH *Jan. 4, 1948* at *7:15 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *March 19, 1947*, to *Dec. 29, 1947*.and that I last saw him alive on *Dec. 29, 1947*.

Immediate cause of death

Acute dilatation of heart

Due to

Hypertensive cardiovascular disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. Peyton Ritchings, M.D.

D. or other

Address

Annapolis, Md.

Date signed

Jan. 9, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00124

468

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County

City or town

Anne Arundel
Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

37 years

Hospital, institution, or street address where death occurred:

52 Northwest St

How long in hospital or institution?

3. (a) FULL NAME

Joseph Hillary

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Col.

Married

6. (b) Name of husband or wife

Mary C. Hillary

7. Birth date of deceased (mo., day, yr.)

August 28, 1888

(e) If alive, give age, years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

59

4

10

9. Birthplace

Davidsonville A.A. Co Md

(Town, county, and state)

10. Usual occupation

Electricians Helper

11. Industry or business

None

MOTHER FATHER

12. Name

Henry Hillary

13. Birthplace

Davidsonville Md.

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mrs Mary C. Hillary

Address

52 Northwest St.

17. Burial

Date thereof January 18-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Brewers Hill

Location

West St. Extended

18. Funeral director

Mrs Charles H. Hicks

Address

45 Northwest St Annapolis

19. Date rec'd by registrar

Jan. 12 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County A.A. Co.

City or town

Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

52 Northwest

(If rural, give LOCATION)

2.(a) If veteran, name war

World War I

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Jan 7, 1948 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 10, 1947, to Jan 7, 1948

and that I last saw him alive on 18.

Immediate cause of death

Inflammation of Stomach

DURATION

20 min.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 40 Northwest St Annapolis Date signed Jan 17 1948

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124B

00125

21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Anne Arundel

City or town..... Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3.0 days

Hospital, Institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?..... 3.0 days

3. (a) FULL NAME

maggie Hillary

4. Sex

F

5. Color or race

C

6.(a) Single, married, widowed, or divorced

M

6.(b) Name of husband or wife

George Hillary

7. Birth date of deceased (mo., day, yr.)

Aug. 1885

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Anne Arundel Co. Md.

(Town, county, and state)

10. Usual occupation.....

Domestics

11. Industry or business

12. Name..... John W. S. Snowden

13. Birthplace..... St. L. Co. Md.

14. Maiden name..... Janette Snowden

15. Birthplace..... St. L. Co. Md.

16. Informant..... George Hillary

Address..... Davidsonville, Md.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... Jan. 18, 1948
(month) (day) (year)

Cemetery or crematory..... Davidsonville

Location..... Davidsonville, Md.

18. Funeral director..... J.B. Johnson

Address..... Annapolis Md. P.O. Box 462

Jan. 18, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Russell - Davidsonville
(If outside city or town limits, write RURAL and give nearest town)Street No..... Riva Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 15, 1948 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 16, 1947, to Jan. 15, 1948

and that I last saw h.c. alive on Jan. 15, 1948

Immediate cause of death.....

Cardiorespiratory failure

DURATION

Due to..... Portal cirrhosis of liver

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

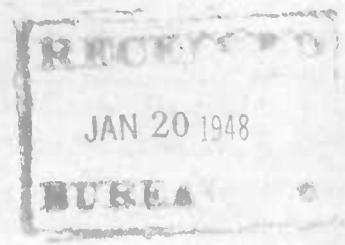
Means of Injury.....

Injured at work?

23. SIGNATURE..... E. Peyton Ritchie, M.D.

M. D. or other

Address..... Annapolis, Md. Date signed Jan. 15, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

87d

Not
CB00126
28

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County... Anne Arundel

City or town... Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 8 days

3. (a) FULL NAME

BRADY HOFFMAN

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Separated

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 4, 1919

6. (c) If alive, give age

years

8. AGE:

Years
28Months
8Days
24If less than one day
hrs. min.

9. Birthplace

North Carolina

(Town, county, and state)

10. Usual occupation

Truck Driver

11. Industry or business

FATHER 12. Name Brady Hoffman

13. Birthplace North Carolina

MOTHER 14. Maiden name Jula Saunders

15. Birthplace South Carolina

16. Informant Hospital Records

Address Crownsville, Maryland

17. Burial Date thereof Jan. 31, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Nat'l Cemetery

Location Washington, D.C.

18. Funeral director John C. Robinson

Address 1313-16th St. N.W. Wash., D.C.

19. Date rec'd by registrar Jan. 30, 1948

Date rec'd by registrar

E. Joyce Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Washington, D. C. County

City or town... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No... 1818 Coran

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28th

19. 48 at 3:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20th 19. 48 to January 28th, 19. 48

and that I last saw him alive on January 27th 19. 48

Immediate cause of death

Multiple Sclerosis

Known to us

since 1/20/48

Due to

Due to

Other conditions Psychosis With Multiple Known to us

Sclerosis since 1/20/48

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

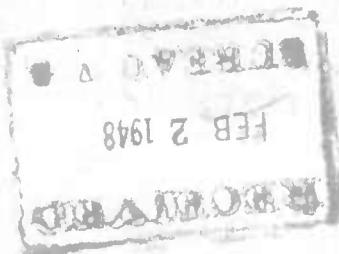
Injured at work?

23. SIGNATURE

M. D. or other

Address Crownsville, Maryland Date signed 1/28/48

Clarissa & Kahl
Williams
Shroder St.
Baltimore
Md.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00159
83a

CERTIFICATE OF DEATH

Reg. Dist. No. L. 4747

1. PLACE OF DEATH:
 County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town) 20 yrs.
 How long in above place of death? 20 yrs.
 Hospital, Institution, or street address where death occurred: 300 Berlin Ave.
 How long in hospital or institution? 3

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 300 Berlin Ave.
 (If rural, give LOCATION)

3. (a) FULL NAMEJames Edward Humphrey**3. (b) Social Security Number**

4. Sex <u>M</u>	5. Color or race <u>C</u>	6. (a) Single, married, widowed, or divorced <u>M.</u>
6. (b) Name of husband or wife <u>Blanche Smith Humphrey</u>		
7. Birth date of deceased (mo., day, yr.) <u>Dec. 18, 1887</u>		
6. (c) If alive, give age <u>60</u> years		
8. AGE: Years <u>60</u>	Months	Days
If less than one dayhrs.min.		

9. Birthplace Florida
(Town, county, and state) Contractor10. Usual occupation Contractor

11. Industry or business

12. Name George Humphrey
MOTHER FATHER13. Birthplace Fla.14. Maiden name McGraw15. Birthplace Fla.16. Informant Mr. Blanch HumphreyAddress 300 Berlin Ave.Burial 1 - 31 - 48
(Burial, cremation, or removal, which?)Cemetery or crematory Mt. Auburn Cem.Location Baltimore, Md.18. Funeral director Mathias & Francis H. HumphreyAddress 578 W. Biddle St.19. 1/30 19. 48 Registrar R. W. Hedrick
(Date rec'd by registrar)**MEDICAL CERTIFICATION**20. DATE OF DEATH January 27 1948, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 1946, to Jan 26 1948

and that I last saw him alive on Jan 16 1948

Immediate cause of death Cerebral HemorrhageDURATION
2Due to Arterio-sclerous

Due to

Other conditions Cystitis, Prostatitis

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. B. Bigelow M. D. or otherAddress 501 Cherry Hill Rd. Date signed 1-27-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00127

CERTIFICATE OF DEATH

Reg. Dist. No.

bc

28

1. PLACE OF DEATH: Anne Arundel
 County.....
 City or town..... Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2½ mos.
 Hospital, institution, or street address where death occurred: Crownsville State Hospital
 How long in hospital or institution?..... 2½ mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 803 Franklin St. ✓
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 LLOYD JACKSON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	unknown

6.(b) Name of husband or wife..... ---

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) unknown

8. AGE: Years Months Days It less than one day
 approximately 60 years hrs. min.

9. Birthplace..... unknown
 (Town, county, and state)

10. Usual occupation..... unknown

11. Industry or business..... Unknown

MOTHER FATHER
 12. Name..... Unknown

13. Birthplace.....

14. Maiden name..... Unknown

15. Birthplace.....

16. Informant..... Hospital records

Address..... Crownsville, Maryland

17. Burial..... Date thereof..... 1/16/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Auburn

Location..... Md

18. Funeral director..... Leo S. Nelson

Address..... 1303 Prestonman St

19. Date rec'd by registrar..... 1/15/48
 (Date rec'd by registrar) Adm. H. Hedrick
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 13 1948 at 8:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 December 2 1947 to Jan. 13 1948
 and that I last saw h. im. alive on January 13 1948

Immediate cause of death..... known to us
 General Arteriosclerosis since 12/2/47

Due to.....

Due to..... Psychosis with Cerebral
 Arteriosclerosis known to us since 12/2/47

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... --- Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... Jacob Mengersten M.D.

M. D. or other.....

Date signed.....

Base
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00128
468

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County

Anne Arundel

City or town

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

18 Northwest Street

How long in hospital or institution?

3. (a) FULL NAME

Frank Jewell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male White**Married*

6. (b) Name of husband or wife

Amy E. Jewell

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

December 31st 1875

8. AGE:

Years

Months

Days

If less than one day

73 0 19

hrs.

min.

9. Birthplace

Annapolis, Md.

(Town, county, and state)

10. Usual occupation

Ret. Blacksmith U.S.N.

11. Industry or business

MOTHER FATHER

12. Name

Jasper Jewell

13. Birthplace

Maryland

14. Maiden name

Priscilla Hopkins

15. Birthplace

Maryland

16. Informant

Mrs. Frank Jewell

Address

Annapolis, Md.

17. Burial

Burial

Date thereof

1/22/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Anne's Cemetery

Location

Annapolis, Md.

18. Funeral director

John W. Taylor Son

Address

Annapolis, Maryland.

19. Date rec'd by registrar

Jan. 22 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Anne Arundel

City or town

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.

18 Northwest St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

*Jan 19**48*

at 5:30p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*July**47*to *Jan 19 48*and that I last saw h.w. alive on *Jan 19 48*

19 48

Immediate cause of death

Carcinoma Stomach

DURATION

8 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operation. *Carcinoma of entire*
Stomach Date of op. *July 1947*

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

George C. Basal

M. D. or other

Address *Annapolis, Md.* Date signed *1. 21. 48*

RECOVERY

JAN 23 1948

ST 83A

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0C129

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

4 mo.

3. (a) FULL NAME

EDITH MAY JONES

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife

William Edward Jones

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb. 5, 1865

8. AGE:

Years
82Months
11Days
1If less than one day
hrs. min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

12. Name Joseph O. Fowler

13. Birthplace Maryland

14. Maiden name Kate S. Leitch

Maryland

15. Birthplace

16. Informant Mr. William S. Jones

Address Parole, Maryland

17. Burial

(Burial, cremation, or removal. Which?) Date thereof 1-17-48

(month) (day) (year)

Cemetery or crematory Davidsonville Methodist

Location Davidsonville, Maryland

18. Funeral director Ben L. Hopping and Son

Address 170-172 West St. Annapolis, Md.

19. Jan 17, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Parole nr. Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 13, 1948, at 6:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6 Dec. 1946, to 13 Jan. 1948,

and that I last saw her alive on Jan. 13, 1948.

Immediate cause of death

Cardiorespiratory failure

Due to

Chronic nephritis
(glomerulonephritis)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

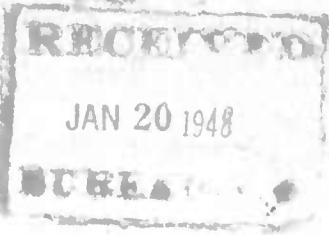
Means of injury

Injured at work?

23. SIGNATURE E. Peyton Stithenix, M.D.

M. D. or other

Address Annapolis, Md. Date signed Jan. 13, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00130

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

County

Anne Arundel
Point Pleasant - P.O. Brooklyn 25
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Solon Knight

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m.

w.

Married

6. (b) Name of husband or wife

Emma Krieg

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

77

years

April 19 - 1875

8. AGE:

Years

Months

Days

If less than one day

72

9

5

hrs.

min.

9. Birthplace

(Town, county, and state)

Odenton, Md.

10. Usual occupation

Farmer. (Retired)

11. Industry or business

General

MOTHER FATHER

12. Name

Dennis G. Knight

13. Birthplace

Anne Arundel Co.

14. Maiden name

Maryjoy E. Turner

15. Birthplace

Anne Arundel Co.

16. Informant

Mrs. Solon Knight & wife

Point Pleasant, Md.

Address

Burial

Date thereof

1/27

(month) (day) (year)

Cemetery or crematory

Nichol Memo. Church

Location

Odenton, Md.

18. Funeral director

Thomas W. Dugleton

Address

Glen Burnie, Md.

19. Date rec'd by registrar

1/26

1948

Z. J. O. D. L. B.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne Arundel

City or town Point Pleasant (Brooklyn 25 Md. P. O.)
(If outside city or town limits, write RURAL and give nearest town)

Street no.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 24 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

19...

and that I last saw him alive on

19...

Immediate cause of death

General anesthesia

DURATION

?

Due to

Sesquicardiac

Due to

had gradually failing in health

Other conditions

No further information

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide NO Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Solon G. Knight

Physician Medical Examiner D. or other

Address: Glen Burnie, Md. Date signed: 1/26/48

RECORDED

JAN 28 1948

F. REAGAN

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

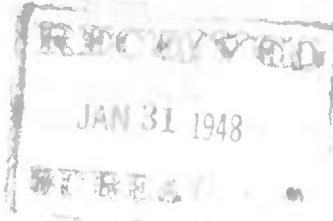
00133-24
Registered No.

1. PLACE OF DEATH: (a) Baltimore City, Maryland <i>announced</i> (b) Street address <i>2 Leonard Ave</i> (c) Hospital or institution:		2. USUAL RESIDENCE OF DECEASED: (a) State <i>Md</i> (b) County <i>Anne Arundel</i> (c) City or town <i>Baltimore 25</i> <small>(If outside city or town limits, write RURAL and give town)</small> (d) Street No. <i>2 Leonard Ave</i> <small>(If rural give location)</small> (e) Citizen of foreign country? <i>No</i> (Yes or No) <small>If yes, name country:</small>	
(d) Length of stay in hospital or inst. (yrs., mos., or days) <i>co.</i>		(e) Length of stay in Baltimore (yrs., mos., or days) <i>life</i>	
3 (a) FULL NAME <i>Caroline Miles</i>			
3 (b) If veteran, name war <i>/</i>		3 (c) Social Security Account No. <i>/</i>	
4. Sex <i>Female</i>	5. Color or race <i>white</i>	6 (a) Single, married, widowed, or divorced. <i>single</i>	
6 (b) Name of husband or wife <i>John Miles</i>		6 (c) If alive, give age <i>90</i> years	
7. Birth date of deceased (mo. day, yr.) <i>July 24, 1864</i>			
8. AGE: Years <i>93</i>	Months <i>5</i>	Days <i>17</i>	If less than one day hr. <i>/</i> min. <i>/</i>
9. Birthplace <i>Baltimore</i> (Town, county, and state)			
10. Usual Occupation <i>housewife</i>			
11. Industry or business <i>/</i>			
MOTHER FATHER	12. Name <i>Makert Beissler</i>	Duration <i>/</i>	
	13. Birthplace <i>Germany</i>	<i>/</i>	
	14. Maiden Name <i>Eliza Beyerbach</i>	<i>/</i>	
	15. Birthplace <i>Germany</i>	<i>/</i>	
	16 (a) Informant <i>Katie Miles & Dishes</i>	Other Conditions <i>cardiovascular</i>	
(b) Address <i>2 Leonard Ave</i>	<i>liver disease</i> (Include pregnancy within 3 months of death)		
17 (a) <i>Burial</i> (b) Date thereof <i>14 Jan 48</i> (Burial, cremation, or removal) (month) (day) (year)	Date of operation <i>/</i>		
(c) Cemetery or crematory <i>Meadow Ridge</i>	Major findings of operation: <i>/</i>		
Location <i>Dorsey - Reed</i>	of autopsy: <i>/</i>		
18 (a) Funeral director <i>F. D. Wippert & Son</i>	22. If death was due to external causes, fill in the following:		
(b) Address <i>130 Eutaw Place</i>	(a) Accident, suicide, or homicide <i>/</i>		
19 (a) <i>1/12/48</i> (b) <i>R. W. Hedrick</i> (Date rec'd by registrar)	(b) Date of occurrence <i>/</i> at <i>/</i> M <i>/</i>		
	(c) Where did injury occur? <i>(City or town) (County) (State)</i>		
	(d) Did injury occur about home, on farm, industrial place, in public place? <i>While at work?</i> (Specify type of place)		
	(e) Means of injury <i>/</i>		
	23. Signature <i>H. J. Summers</i> M. D.		
	Address <i>10750 Reister Rd</i> Date signed <i>1/1/48</i>		

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1220
00134

20

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

Anne Arundel

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

2 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Roberta Nick

4. Sex

female

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

—

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Oct. 18, 1947

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Cumberland, Md. *PA*

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER

Damey Nick

Shadyside, Md.

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial.....

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

(Date rec'd by registrar)

Date thereof.....
(month) (day) (year)

Chew Chapel

Owensville, Md.

William Geese, II

108 Washington St.

Jan. 6, 1948

2 M. Chaytor

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For born infants give residence of mother)

State.....

Maryland County.....

City or town.....

Cumberland

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

July 4, 1948, at 6:30 p.m.
Postmortem Examination
and that I last saw her alive on July 4, 1948.

Immediate cause of death.....

Convulsions

Due to.....

Strangulated umbilical hernia

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town) (County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

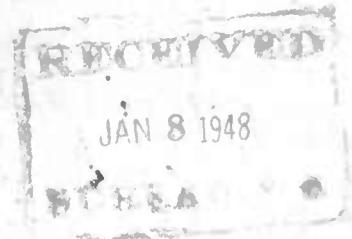
Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

John M. Caffey, M.D., Examiner
Annapolis, Md. Date signed.....
1-4-48



PLEASE WRITE PLAINLY, WITH UNADING INK. Supply every item of information carefully. This perfect age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00135

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County.....

Luree Crumel

City or town.....

Maryland

How long in above place of death?

(If outside city or town limits, write RURAL and give nearest town)

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ida May Ozman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. White Widowed

8. (b) Name of husband or wife.....

Harry C. Ozman

(Deceased)

7. Birth date of deceased (mo., day, yr.)

(b) If alive, give age years

Dec. 16-1864

8. AGE:

Years Months Days

If less than one day

83 - 24 - mrs. min.

9. Birthplace.....

Baltimore

(Town, County, and state)

10. Usual occupation.....

none

11. Industry or business

Chas. Chaffman

12. Name.....

Baltimore

13. Birthplace.....

Baltimore

14. Maiden name.....

Matilda Brown

15. Birthplace.....

Baltimore

16. Informant.....

Ida May Berger

Address.....

1433 Woodall St. Baltimore

B.

Date thereof.....

(month) (day) (year)

1 - 13 - 48

17. (Burial, cremation, or removal, which?)

Cremation

Cemetery or crematory.....

Fairview

Location.....

E. North Ave.

18. Funeral director.....

J. J. Buckley

Address.....

130 E. North Ave.

19. (Date rec'd by registrar)

1/10 48 O.M. Dept.

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 9 48 11 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 3-48 to Jan. 9-48 to

and that I last saw her alive on Jan. 8-48 to

Immediate cause of death.....

Toxa pneumonia.

Due to.....

Due to.....

Other conditions.....

Semicrystalline clots

Endothelial tissue

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op. /

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

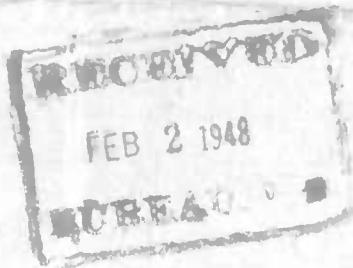
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

M. D. or other

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Martin

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 93d
CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
Anne Arundel
County
City or town Mago Vista
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, institution, or street address where death occurred:
Mago Vista
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Maryland County Anne Arundel
City or town Mago Vista
(If outside city or town limits, write RURAL and give nearest town)
Street No. nr Annapolis, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME
CHARLES H. PARKER

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Widowed	
6.(b) Name of husband or wife Gertrude A. Parker			
6.(c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) October 6, 1868			
8. AGE: Years 79-	Months 3	Days 9	If less than one day hrs. min.
9. Birthplace New Jersey (Town, county, and state)			
10. Usual occupation Farmer			
11. Industry or business			
12. Name Unknown			
13. Birthplace Unknown			
14. Maiden name Unknown			
15. Birthplace Unknown			
16. Informant L. H. Schooler			
Address Mago Vista			
17. Burial Date thereof 1-18-48 (Burial, cremation, or removal. Which?) (month) (day) (year)			
Cemetery or crematory Cedar Hill Cemetery			
Location Hightstown, New Jersey			
18. Funeral director Ben L. Hopping and Son			
Address 170-172 West St. Annapolis, Md.			
19. Jan. 17 48 7 PM (Date rec'd by registrar) <i>Jan 17 48 7 PM</i> <i>Death</i> Registrar			

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH Jan 15, 1948 at 2 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 47 to Jan. 15, 1948 and that I last saw him alive on Jan. 15, 1948

Immediate cause of death Coronary thrombosis

Due to Chronic myocarditis

Due to Hypertensive Cardiovascular disease

Other conditions Cachexia

DURATION 2 weeks

5 yrs.

10 yrs.

(Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.

Autopsy results.
PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

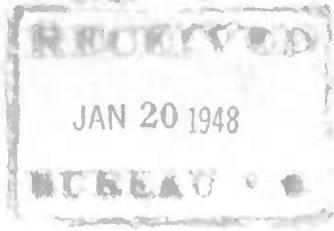
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *James J. Martin, M.D.* M. D. or other

Date signed 1-16-48

Address Annapolis, Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Unimportant. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00138

468

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County

Anne Arundel

City or town

Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hosp't.

How long in hospital or institution?

3. (a) FULL NAME

Irvin W. Pumpfrey

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife

Addie E. Pumpfrey

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

July 1st 1901

8. AGE:

Years

46

Months

17

Days

17

If less than one day

hrs.

min.

9. Birthplace

C. A. Co. Md.

(Town, county, and state)

10. Usual occupation

Plasterer

11. Industry or business

MOTHER FATHER

John Pumpfrey

C. A. Co. Md.

Julia Speeks

C. A. Co. Md.

16. Informant

Address

Addie E. Pumpfrey

Millersville Md.

17. Burial

Cemetery or cremation

Date thereof

Jan. 20, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

(month) (day) (year)

Glen Haven Memorial

Glen Burnie Md.

Location

John W. Fay C. & Son

18. Funeral director

Address

Crownfield Md.

19. Date rec'd by registrar

Jan. 20, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Millersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Jan. 18

19. 48

at 9¹⁰_{th} M

21. I CERTIFY that death occurred on the date above stated; That I attended deceased from

Jan. 14 1948 to Jan. 18 1948

and that I last saw him alive on Jan. 18 1948

Immediate cause of death

Carcinoma of pyloric
end of stomach unknown
Causing obstruction

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

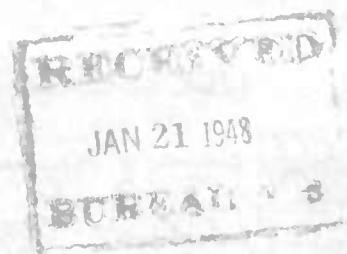
Injured at work?

23. SIGNATURE

John M. Claffey M.D.

M. D. or other

Address Annapolis, Md. Date signed 1/19/48



00139

Duplicate

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel Co.

County.....
City or town..... Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ years

Hospital, institution, or street address where death occurred: Emergency Hosp.

How long in hospital or institution? admitted at

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A. A. Co.

City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Calvert St.
(If rural, give LOCATION)

2.(a) If veteran, name war *****

3. (a) FULL NAME Helen Queen

4. Sex Female	5. Color or race Col.	6.(a) Single, married, widowed, or divorced Divorced				

6.(b) Name of husband or wife						
6.(c) If alive, give age years						
7. Birth date of deceased (mo., day, yr.) September 1909						
8. AGE:	Years 38	Months 5	Days	If less than one day	hrs.	min.
9. Birthplace Parole Md. A. A. Co.			(Town, county, and state)			
10. Usual occupation Domestic						
11. Industry or business None						
MOTHER FATHER	12. Name Charles Queen					
	13. Birthplace Parole Md.					
14. Maiden name Emma Wells						
15. Birthplace West River A. A. Co.						
16. Informant Mrs Daisy Cornor						
Address Parole Md.						
17. Burial Date thereof January 25, 1948 (Burial, cremation, or removal. Which?) (month) (day) (year)						

18. Cemetery or crematory Brewer Hill Cemetery

Location West St. Extd.

19. Funeral director Mrs Charles E. Hicks

Address 45 Northwest St. Annapolis Md.

20. Date rec'd by registrar Jan 23 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 20 1948 to Jan. 20 1948 and that I last saw her alive on Jan. 20 1948

Immediate cause of death

Cerebral hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

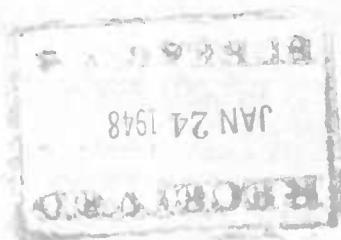
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Peyton Ritchings, M.D.
M. D. or other

Address Annapolis, Md. Date signed Jan 23 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00140

CERTIFICATE OF DEATH

Reg. Dist. No.

23

1. PLACE OF DEATH:

County.....

City or town.....

Anne Arundel
New Berlin, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

13 years

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Lizzie Queen

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

F. Black wedded

6.(b) Name of husband or wife.....

Husband is dead.

7. Birth date of deceased (mo. day. yr.)

Dec. 4 - 1887

6.(c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

60 1 13 hrs. min.

9. Birthplace.....

Anne Arundel Co. Md.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date reg'd by registrar)

Date thereof.....

(month) (day) (year)

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?.....

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 18 1948 at 3 P.M.

21. I CERTIFY that death occurred on the day above stated; that I attended deceased from

19.....to.....19.....

and that I last saw h.....alive on.....19.....

19.....

Immediate cause of death.....

Coronary Occlusion

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?.....

23. SIGNATURE.....

J. H. Packer, M.D.

M. D. or other

Address.....

Date signed.....

11/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a
00141

28

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

Anne Arundel

County.....

Miller'sville, Md. R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

2 years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Severn Cross Roads

How long in hospital or institution?

3. (a) FULL NAME

Gustave E. Reechel

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife..... Marie A. Reechel

Nee; Neika

6. (c) If alive, give age..... 82 years

7. Birth date of

deceased (mo., day, yr.) August 28, 1863

8. AGE: Years Months Days It less than one day
84 4 14 hrs. min.

9. Birthplace..... Danzig, Germany

(Town, county, and state)

10. Usual occupation..... Carpenter (Retired)

11. Industry or business..... Own Business

12. Name..... Carl Reechel

13. Birthplace..... Germany

14. Maiden name..... Ludawikie Meyer

15. Birthplace..... Germany

16. Informant..... Mrs. Charles Green

Address..... Millersville, Md. R.F.D.

17. Burial.....

Date thereof..... Jan. 15, 1948.
(month) (day) (year)

Burial, cremation, or removal. Which?..... Baldwin Memorial Ch. Yard

Location..... Severn Cross Roads, Millersville

18. Funeral director..... Thomas W. Singleton

Address.....

Glen Burnie, Md.

19. 1/15
(Date rec'd by registrar)

158

S. F. O. C. Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Anne Arundel

City or town..... Miller'sville, R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Severn Cross Roads

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 12 1948 at 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1947, to January 12, 1948,

and that I last saw h. l. alive on January 12, 1948.

Immediate cause of death.....

Arterio-sclerotic Heart Disease

DURATION

1 year

Due to.....

Due to.....

Other conditions..... chronic Nephritis

6 months

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

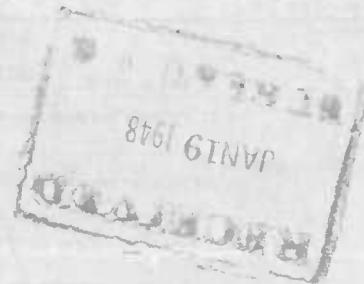
Means of injury.....

Injured at work?

23. SIGNATURE..... Edward J. Bennett, M.D.

M. D. or other

Address..... Gambrills, Md. Date signed..... 1/13/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; if incorrect age is especially important. Physicians: please write the causes of death clearly and logically.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107
830
00143

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

a. a.

City or town.....

Severn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Henry F. Schultz

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Wife

Sister

Married

6. (b) Name of husband or wife

Hector Schultz

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

March 4, 1876

8. AGE:

Years

Months

Days

Unless less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

Germany

10. Usual occupation.....

Gardener Farmer

11. Industry or business

Unknown

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Eminia Clark

Address

17. Mortal, cremation, or removal. When? Date thereof. (month) (day) (year)

1/24/48

Cemetery or crematory.....

Strand ship

Location.....

Anne Arundel Co MD

18. Funeral director.....

Wilson & Son

Address

1219 Lt Col St

19. Date rec'd by registrar

Date

Jan 23, 1948

T. W. Hendrie

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md Anne Arundel

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

Ad

3. (b) Social Security Number

219-16-1820

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Jan 21st

1948 at

M

2L I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan - 19 - 1948 to Jan - 21 - 1948, and that I last saw h. in alive on Jan - 21 - 1948

Immediate cause of death.....

Seizure of heart attack

DURATION

4 days

Due to.....

Due to.....

Other conditions.....

Excessive alcohol

(Include pregnancy within 3 months of death)

1045

Major findings or operations.....

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

Chas. L. Ball Jr M.D. or other

Address: Greenwich Date signed: Jan 21-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a
00101

Reg. Dist. No.

I. PLACE OF DEATH:

County

City or town

Mary Landry

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Agnes Sean

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

W

6.(b) Name of husband or wife

Owen Sean

7. Birth date of deceased (mo. day, yr.)

Oct 22 1871

6.(c) If alive, give age

years

8. AGE:

Years Months Days If less than one day
72 2 27 hrs. min.

9. Birthplace

Md

(Town, county, and state)

10. Usual occupation

Dowrtic

11. Industry or business

Herry Jones

12. Name

Herry Jones

13. Birthplace

May 2 Ireland

14. Maiden name

N/A

15. Birthplace

N/A

16. Informant

Owen Sean

Address

Mary Landry

Date thereof (month) (day) (year)
11/17/48

17. Burial, cremation, or removal. Which?

Cemetery or crematory

Friendship Cem.

Location

Friendship Cem

18. Funeral director

T.G. Handley & Sons

Address

Galaville

19. (Date received by registrar)

1948

M.D. or other

Signature

George W. M. Bayto

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Md

City or town

Mary Landry

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/17

19

48

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 9 1888 to Jan 17 1948
and that I last saw her alive on Jan 16 1888

Immediate cause of death

Cerebral hemorrhage 10 days

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

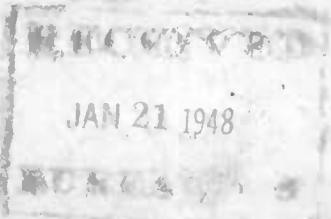
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H.W. Ward
George W. M. Bayto
Date signed 11/17/48



JAN 21 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00145
95c

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Winchester

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Winchester Station

How long in hospital or institution?

3. (a) FULL NAME

Jerome E. Sherman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

Fairie Eakin Sherman

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

January 24th 1905

8. AGE:

Years 42

Months 11

Days 13

If less than one day hrs. min.

9. Birthplace

Massachusetts
(Town, county, and state)

10. Usual occupation

General Contractor

11. Industry or business

Alfred P. Sherman

MOTHER FATHER

12. Name

Basto, Mass.

13. Birthplace

Clarendon Jones

14. Maiden name

Boston, Mass.

15. Birthplace

Mrs. J. E. Sherman

16. Informant

Cornel Hall, Annapolis, Md.

Address

Cremation Date thereof 7/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

T. L. Lincoln Crematory

Location

Premier Geo. Co. Md.

18. Funeral director John W. Taylor, Son

Address

Annapolis, Md.

19. Jan. 7, 1948

(Date rec'd by registrar)

D. J. Lynch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A. Co.

City or town Winchester

(If outside city or town limits, write RURAL and give nearest town)

Street No. 80 Ansel, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 6, 1948 at 1:00 PM

21. I CERTIFY that death occurred on the date above named: *Post mortem Examination*and that the cause of death was *Acute dilatation of Heart* on Aug. 6, 1948.

Immediate cause of death

Acute dilatation of Heart

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M. Gaffy M.D. Deputy medical examiner

M. D. or other

Address Annapolis, Md. Date signed 1-6-48

Registrar

RECEIVED

JAN 9 1948

THE HORN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. True correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

00146

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.

City or town Germantown

(If outside city or town limits, write RURAL, and give nearest town)

40 Years

How long in above place of death?

Hospital, institution, or street address where death occurred:

17 Brewer Ave.

How long in hospital or institution?

3. (a) FULL NAME

Frank Smith

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Ivah E. Smith

7. Birth date of deceased (mo., day, yr.)

March 30 1879

6.(c) If alive, give age years

67

8. AGE: 68 Years

Months 9

Days 22

If less than one day 13

hrs.

min.

9. Birthplace

Smithville, Md.

(Town, county, and state)

10. Usual occupation

Retired

Telephone Co.

11. Industry or business

William Smith

MOTHER FATHER

12. Name

Lucy Childs

13. Birthplace

Maryland

14. Maiden name

Maryland

15. Birthplace

Maryland

16. Informant

Ivah E. Smith

Address

17 Brewer Ave.

17. Burial

Date thereof Jan 24 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Cedar Bluff

Location

Annapolis, Md.

18. Funeral director

B.L. Hopping & Son

Address

170 West Street, Annapolis, Md.

Jan 24 1948

(Date rec'd by registrar)

7-10-48

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County A.A.

City or town Germantown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 Brewer Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 21

1948 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 15 1948 to Jan 21 1948

and that I last saw him alive on Jan 21 1948

Immediate cause of death

Cerebral Hemorrhage
Pt. Necropsy

DURATION

6 days
6 days
2 days

Due to

Due to

Other conditions

Arteriosclerosis

when

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George C. Board M. D. or other

Address Annapolis Date signed 1-23-48

RECEIVED

JAN 27 1948

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92b

00147

21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Anne Arundel

City or town

P.O. Pasadena, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All life.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Springfield Spencer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Married

6. (b) Name of husband or wife

Widowed

7. Birth date of deceased (mo., day, yr.)

Sept. 23 - 1894

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

53

3

hrs.

min.

9. Birthplace

Anne Arundel County, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

William Spencer

12. Name

Maryland

13. Birthplace

Charlotte Turner

14. Maiden name

Maryland

15. Birthplace

Maryland

16. Informant

Widowed Spencer (wife)

Address

P.O. Pasadena, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 1-21-48
(month) (day) (year)

Cemetery or crematory

Magothy

Location

Anne Arundel Co., Md.

18. Funeral director

William A. Jackson

Address

916 Penna Ave. Balt. I.

19. (Date recd by registrar)

1/19 1948

A.W. Gedrich

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 15 1948 at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1947 to January 1948

and that I last saw him alive on January 16 1948

Immediate cause of death

Artificial respiration

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Blue Bell, Md. Date signed 1/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If be correct are especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

51d

BC

00148

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Anne Arundel
 County.....
 Crownsville
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 mos.
 Hospital, Institution, or street address where death occurred: Crownsville State Hospital
 How long in hospital or institution? 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County.....
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 614 Stockton St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

ALBERT STENSON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: ---

7. Birth date of deceased (mo., day, yr.) 1877
 .8.(c) If alive, give age years8. AGE: Years Months Days If less than one day
 70 --- --- hrs. min.9. Birthplace Alabama
 (Town, county, and state)

10. Usual occupation none

11. Industry or business ---

12. Name Ransom

13. Birthplace ---

14. Maiden name Elizabeth Carter

15. Birthplace ---

16. Informant Hospital records

Address Crownsville, Md.

17. Cremation Date thereof 1/10/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Loudon Park.

Location Federick Ave.

18. Funeral director Metropolitan Funeral Home Inc.

Address 9517 N. Mount St

19. 1/8 1948 D.W. Hedrick

(Date rec'd by registrar) (Signature) (Initials)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1948 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5 1947 to Jan. 6 1948 and that I last saw him alive on Jan. 6 1948

Immediate cause of death Cancer of the penis Known to us since 8/5/47

Due to.

Due to.

Other conditions Known to us since 8/5/47
 Psychosis with Cerebral Arteriosclerosis
 (Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results --- Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph Mangerster, M.D.

M. D. or other

Address Crownsville, Md. Date signed 1/6/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00149

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County..... Anne Arundel
 City or town..... Fort George G Meade
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

Station Hospital

How long in hospital or institution? 2 days

3. (a) FULL NAME

JOHN SWARTZ

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male	White	Married
------	-------	---------

6.(b) Name of husband or wife Anna Swartz

7. Birth date of deceased (mo. day, yr.) 6. (c) If alive, give age 41 years

9 January 1906

8. AGE: Years Months Days If less than one day

42	0	6	hrs.	min.
----	---	---	------	------

9. Birthplace Hazel, New York

(Town, county, and state)

10. Usual occupation Soldier

11. Industry or business

12. Name George Swartz

13. Birthplace Lithuania

14. Maiden name Eva Adamitis

15. Birthplace Lithuania

16. Informant Service Record of deceased

Address Fort George G Meade, Maryland

17. Burial Date thereof 17 Jan 1948
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Arlington National Crematory

Location Arlington, Virginia

18. Funeral director Lilly & Zeiler, Inc

Address 403 S. Wolfe St., Baltimore, Md

19. 15 Jan 1948
(Date rec'd by registrar)JAMES N. GOERGER CAPT DSC
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Fort George G Meade

(If outside city or town limits, write RURAL and give nearest town)

Street No. NC-135

(If rural, give LOCATION)

2.(a) If veteran, name war World War II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 January 1948 0850 hrs

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 January 1948 to 14 January 1948

and that I last saw him alive on 0850 hrs 14 January 1948

Immediate cause of death Cardio-vascular collapse

Due to following spinal anesthesia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Hemorrhoids external, internal, severe

Date of op. 14 Jan 48

Autopsy results Pending

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul E. Sieber Capt. MC M. D. or other

Address Ft. George G Meade, Md Date signed 15 Jan 48

RECEIVED

JAN 16 1948

WCRE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00150

CERTIFICATE OF DEATH

Reg. Dist. No. 21

97

1. PLACE OF DEATH:

County A.A.C.

City or town Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary R. Tydings

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife George R. Tydings

7. Birth date of deceased (mo., day, yr.)

Feb. 17th 1855

8. AGE:

Years 92

Months 10

Days 19

If less than one day

hrs. min.

9. Birthplace Annapolis, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name George R. King

13. Birthplace Annapolis, Maryland

14. Maiden name Rebecca Hopkins

15. Birthplace Annapolis, Maryland

16. Informant Edward T. Tydings

Address 1118 Bay Ridge Ave, Eastport, Md.

17. Burial Date thereof Jan. 12, 1948

(Burial, cremation, or removal. When?)

Cemetery or crematory Cedar Bluff Cemetery

Location Annapolis, Maryland

18. Funeral director John M. Taylor Son

Address Annapolis, Maryland

19. Jan. 12, 1948 - Cremated

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A.C.

City or town Annapolis - Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1118 Bay Ridge Ave, Eastport, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 8, 1948, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

April 19, 1947, to Jan. 19, 1948, and that I last saw her alive on Jan. 12, 1948.

Immediate cause of death

Due to Arteriosclerosis generalized.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 1118 Bay Ridge Ave, Eastport, Md. Date signed Jan. 12, 1948

Registrar



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00151
1628

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County.....

Anne Arundel

City or town.....

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Chase Home - Res. Ave.

How long in hospital or institution?

3. (a) FULL NAME

Mary Esther Ogle Warner

4. Sex

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Anthony K. Warner

7. Birth date of deceased (mo., day, yr.)

July 14th 1864

6.(c) If alive, give age.....years

8. AGE:

Years Months Days If less than one day

83

7

4

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

Richard Ogle

12. Name

Maryland

13. Birthplace

Tenny Knight

14. Maiden name

Vermont

15. Birthplace

Mrs. J. L. Donoho

16. Informant

3124 3124 Sequoia Ave Baltimore Md.

Address

Burial

Cemetery or crematory

London Park

Location

Baltimore Md.

18. Funeral director

John M. Taylor Son

Address

Annapolis Md.

19. Date rec'd by registrar

Jan. 20, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

A. A. Co.

City or town

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Chase Home - Res. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 18, 1948 at 10⁰⁰ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 13, 1948 to Jan. 18, 1948

and that I last saw h.e. alive on Jan. 18, 1948

Immediate cause of death

Cardiovascular failure

Due to

diseases respiratory

Senility

Due to Patient died of old age [3/29/48 dec]

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

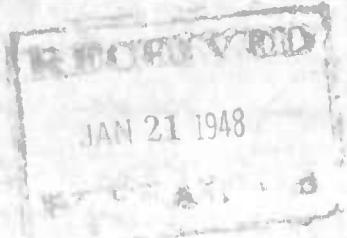
E. Peyton Ritchie

M. D. or other

Address

Annapolis, Md.

Date signed Jan. 13, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Inexact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00152

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County ANNE ARUNDELCity or town MT. CARMEL Mr. Road

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

KATHERINE DRUSILLA

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

WIDOWED

6.(b) Name of husband or wife

FRANK H. WELCH

6.(c) If alive, give age

D

years

7. Birth date of deceased (mo., day, yr.)

DEC 1 1869

8. AGE:

Years
78Months
1Days
11

If less than one day

hrs.
.....min.
.....

9. Birthplace

ANNE ARUNDEL Co.

(Town, county, and state)

10. Usual occupation

.....

11. Industry or business

.....

MOTHER FATHER

12. Name

JEFFERSON M. COOKMARYLAND

13. Birthplace

EMMA LINSTEADMARYLAND

14. Maiden name

MRS. MARIE LENZMARYLAND

15. Birthplace

MRS. MARIE LENZMARYLAND

16. Informant

MRS. MARIE LENZMARYLAND

Address

MT. CARMEL Mr. Road

17. BURIAL

Date thereof

1 15 48
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

MT. CARMEL CEMETERY

Location

MT. ROAD

18. Funeral director

JOHN F. DENNY, INC.

Address

715 LIGHT ST -30

19. (Date rec'd by registrar)

1/14/48A. W. HedrichRegistrar
✓ 28

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD

County

ANNE ARUNDELCity or town MT. CARMEL

(If outside city or town limits, write RURAL and give nearest town)

Street No.

MT. ROAD

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

WELCH

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Jan. 12 1948 at 10:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 12 1947 to 1947

13

and that I last saw her alive on Dec. 14 1947 to 1947

1947

Immediate cause of death coronary occlusion

with myocardial

infarction

Due to Coronary sclerosisDue to Generalized arterio-sclerosis

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

O. J. Gaalas M.D.Green Gables-Paxtonian

M. D. or other

Date signed Jan 13 1948

Address

Dr. Gallaudet

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00153

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County

City or town

A. J. A.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Emergency Hospital

How long in hospital or institution?

3. (a) FULL NAME

Barry W. White

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored, married

6. (b) Name of husband or wife

Mollie White

7. Birth date of deceased (mo., day, yr.)

July 11 1933

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day hrs. min.

44

14

RECORDED

JAN 27 1948

RECORDED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00154

94a

B

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Anne Arundel

County

Waterbury

City or town

(if outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 64 yrs.

Hospital, institution, or street address where death occurred:

Boxx General Highway

How long in hospital or institution?

3. (a) FULL NAME

BENJAMIN BRYAN WILLIAMS

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

B. (b) Name of husband or wife

Fannie Meade Williams

7. Birth date of deceased (mo., day, yr.)

October 1, 1883

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

64

3

27

hrs.

min.

9. Birthplace

Waterbury

A. A. Co. Maryland

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farming

MOTHER FATHER

R. Thomas Williams

13. Birthplace

Maryland Maryland

14. Maiden name

Fannie E. Bryan

15. Birthplace

Maryland

16. Informant

Mrs. Fannie Meade Williams

Address

Waterbury, A. A. Co. Maryland

17. Burial

Date thereof Jan 31/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Baltimore Cemetery

Location

Annapolis, Md.

18. Funeral director

Ben L. Hopping and Son

Address

170-172 West St. Annapolis, Maryland

19. (Date rec'd by registrar)

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Anne Arundel

City or town Waterbury

(if outside city or town limits, write RURAL and give nearest town)

Street No. Rural

Waterbury P.O.

(if rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 28

19 48 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 28 1948 to 1-28 1948

and that I last saw h. in alive on Jan 28 1948

1948

Immediate cause of death Coronary

occlusion.

Due to Hemorrhage in the brain wall

DURATION

30 min

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ostman Neuman

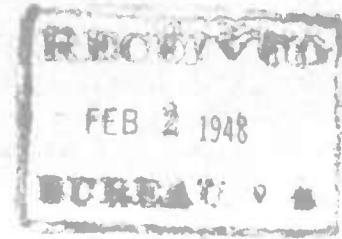
M. D. or other

Address

Millersville Md. Date signed Jan 29 1948

19

19



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00155

CERTIFICATE OF DEATH

Reg. Dist. No. 22

Please write plainly with unfading ink. Supply every item of information carefully. We do not age

1. PLACE OF DEATH:

County Anne Arundel
City or town Rural - Towel
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 years +Hospital, Institution, or street address where death occurred: District Training SchoolHow long in hospital or institution? 15 years +

3. (a) FULL NAME

Mamie Alice Williams

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

singl

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1890

6. (c) If alive, give age years

8. AGE: Years 58 Months _____ Days _____ If less than one day
..... hrs. min.9. Birthplace Washington, D.C.
(Town, County, and state)10. Usual occupation none11. Industry or business none12. Name William Williams

13. Birthplace

14. Maiden name Anna Betty

15. Birthplace

16. Informant D. T. J. recordsAddress Laurel Md17. Burial Date thereof 1/24/48
(Burial, cremation, or removal. Which?) Date thereof
(month) (day) (year)Cemetery or crematory 1400 Chapin StreetLocation Wash. D.C.18. Funeral director Chancery C. LeverAddress Washington, D.C.19. Date rec'd by registrar Jan 24 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D.C.City or town Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. St. Elizabeth's Hosp.

(If rural, give location)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24-48 at 2nd A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 18 1934 to 1-24-48and that I last saw her alive on 1-23-48 at 19.Immediate cause of death Bronchitis - Pneumonia DURATION 3 daysasteno - pleurosis 5 yrs.
Paralytic Agitans 5 yrs.Due to Mental deficiency - in health lifeOther conditions arthritis since 1941
cystitis since 1-12-48

(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

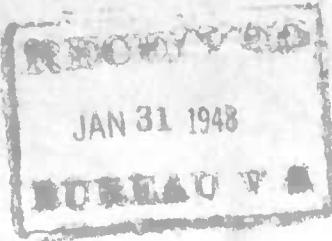
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.

M. D. or other James Gould, M.D.
Address Dist. Tr. School Laurel Date signed 1/24/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00156
468

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel County

City or town Pasadena
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:

How long in hospital or institution? Home

3. (a) FULL NAME
Raymond Williams

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife Bassie Williams

7. Birth date of deceased (mo., day, yr.) December 28, 1893

8. AGE: Years	Months	Days	If less than one day
54	0	17	hrs. min.

9. Birthplace California
(Town, county, and state)

10. Usual occupation Riveter

11. Industry or business Maryland Drydock

MOTHER FATHER
12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Bessie Williams
Address Bodkin Ave. Pasadena, Md.

17. Burial Date thereof Jan. 17, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery Cemetery

Location Mt. Olivet, Baltimore, Md.

18. Funeral director Wm. Cook, Inc.
Address 1217 St. Paul Street, Baltimore, Md.

19. 1-16 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Pasadena
(If outside city or town limits, write RURAL and give nearest town)

Street No. Bodkin Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (b) Social Security Number

216 12 9141

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1948, a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 28, 1947, to Jan. 9, 1948,
and that I last saw him alive on Jan. 9, 1948.

Immediate cause of death Generalized Acute

Debilitating

Due to Internal Inflammation

Other conditions

Major findings of operations Carcinoma, Common

Breast Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P.W. Richard
T.S. Carter, Jr. M. D. or other

Date signed 1/15/48

Address

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00160
94a

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Anne Arundel

City or town..... Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

21 Years

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

WILLIAM A. WOODEY

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife..... Jessie M. Woodey

Nee Stallings

6.(c) If alive, give age..... 51 years

7. Birth date of deceased (mo., day, yr.) December 9, 1881

8. AGE: Years Months Days If less than one day

66 1 7 hrs. min.

9. Birthplace..... Baltimore, Md.
(Town, county, and state)

10. Usual occupation..... Chaefuffer

11. Industry or business..... Davidson Transfer & Storage

12. Name..... John Woodey

13. Birthplace..... Virginia

14. Maiden name..... Dora Stumpf

15. Birthplace..... Germany

16. Informant..... Mrs. Jessie M. Woodey

Address..... 326 Railroad Ave., Glen Burnie, Md.

17. Burial..... Date thereof..... Jan. 19, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mayo Cemetery

Location..... Mayo, Maryland

18. Funeral director..... Thomas W. Singleton

Address..... Glen Burnie, Md.

19. (Date rec'd by registrar)..... 1/18 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State..... Anne Arundel

County..... Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 326 Railroad Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

216 05 8655

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 16 1948 at 11.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

AUGUST 1947 to JAN 16 1948

and that I last saw him alive on JAN 14 1948

Immediate cause of death..... CORONARY THROMBOSIS

DURATION

Due to..... THROMBUS OF CORONARY
BLD. VESSELS

Due to..... UNKNOWN

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... Harry F. Zanger, M.D.

M. D. or other

Address..... Glen Burnie, Md. Date signed..... 1/17/48

Registrar

